OP-36 **USING RESEARCH TO INFORM POLICY AND PRACTICE: INCENTIVISING COMMUNITY MANAGEMENT OF HEALTH SERVICES IN NAGALAND**

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Background Nagaland enacted the 2002 Communitisation of Public Institutions and Services Act by providing communities with resources as well as responsibilities to manage service delivery in a number of sectors, including health. There remain shortcomings in improving health service delivery through community-based committees constituted under this legislation. The Oxford Policy Management in collaboration with a local partner, Entrepreneurs Associates, undertook an assessment of the functioning of these community-level committees. Insights from these findings informed the design of the Community Action for Health & Nutrition programme (CAHN), as part of the World Bank's technical assistance to the Government of Nagaland.

Methods We undertook fieldwork for a situation analysis across four districts of Nagaland (Phek, Kiphire, Tuensang and Dimapur) covering a total of 19 committees at village and public health facility level. We used the frameworks of Falisse *et al*.[1] and Rifkin *et al*.[2] to guide data collection and analysis. We conducted focus group discussions and in-depth interviews with a range of stakeholders including community members who were part of the health committees, those who were not part of those committees, health staff and other government functionaries.

Findings & discussion Our situation analysis revealed that the committees were operational and the committee members were largely keen to help. However, members were insufficiently trained and not aware of their rights and responsibilities. The committees did not have adequate resources to drive significant improvements in worker and facility performance. Lack of importance given to health promotion and preventative care undermined allocative efficiency by diverting most resources towards basic curative care. We found limited cross-sectoral coordination at village level with regard to health determinants like nutrition, water, sanitation and hygiene. There was a lack of structured and regular outreach activities in remote areas. Health staff instead of community members still largely dominated decision processes within the committees.

Given the lack of understanding of their roles and responsibilities, the largely monitoring-focused role that the committees were undertaking, is limited to the lower rungs of the 'participation ladder' described by Arnstein[3]. Besides, the inconsistent and inadequate provision of the funds to the committees seems to contribute to a feeling of inability to undertake any significant action.

The Community Action for Health & Nutrition programme (CAHN), designed using these findings, interactions with government officers. It comprises a review of literature, aims to overcome the mentioned challenges through training of committee members, increasing the level of resources available to committees and using a result-based financing mechanism whereby funds are released on the achievement of certain pre-defined health-related indicators. These indicators are devised such as to incentivize outreach activities, improve the oversight and coordination role of higher-level facilities towards lower-level facilities (with the incentives of the former depending on the performance of the latter), and incentivize spending on health promotion and preventative care.

The CAHN programme was piloted in 17 sites, corresponding to 11 Village Health Committees, three Health Sub Centre Committees, one Primary Health Centre Committee and two Community Health Centre Committees) since late 2015. Lessons from the pilot are the following: (1) continuous follow-up and support is crucial for implementation of the programme approach; (2) collecting baseline data on key results

indicators as part of the initial landscaping and mobilisation of committee members is extremely challenging and time consuming due to data availability issues and difficulty in determining the denominator; (3) development of an action plan is an iterative process and committee members need guidance towards thinking through actions that will contribute towards not just the physical improvement of the facility but also towards improvement of key health indicators. Having a pre-identified menu of desired activities is important in this regard; (4) interest and leadership of the committee chair is key to success of the approach; (5) simplifying financial reporting is essential considering that most transactions at the local level happen in cash rather than through cheques; and (6) delay in fund release for committees diminishes the motivation of committee members. These lessons will be taken into account while further rolling out the CAHN programme in late 2016. The programme is expected to run for six years till 2021.

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